# California Children's Services (CCS) Redesign Performance Measure Quality Subcommittee

CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

May 30, 2024

# Agenda

| | |
|---|---|
| Welcome and Meeting Information | 11:00-11:10 |
| Roll Call | 11:10-11:15 |
| Background and Authorizing Statute | 11:15-11:20 |
| February Meeting Summary and Department of Health Care Services (DHCS) Decision Points | 11:20-11:30 |
| Overview of Demographic Dimensions Dashboard | 11:30-12:00 |
| Review of Recommended Tier 1 Measures and DHCS Decisions | 12:00-12:45 |
| Public Comment | 12:45-12:55 |
| Next Steps | 12:55-1:00 |

# Housekeeping & Webex Logistics

## Do's & Don'ts of Webex

- Participants are joining by computer and phone
  - For assistance with the WebEx invite, email CCSProgram@dhcs.ca.gov with the Subject Line: "CCS Redesign Performance Measure Quality Subcommittee"
- Everyone has been automatically muted upon entry
- CCS Redesign Performance Measure Quality Subcommittee members: 'Raise Your Hand' or use the Q&A box to submit questions
- Other participants: Use the Q&A box to submit comments/questions or 'Raise Your Hand' during the public comment period
- To use the "Raise Your Hand" function click on participants in the lower right corner of your chat box and select the raise hand icon
- Live closed captioning will be available during the meeting

**Note**: DHCS is recording the meeting for note-taking purposes

# Workgroup Meeting Logistics

- The CCS Redesign Performance Measure Quality Subcommittee will meet on a quarterly basis
- Between meetings, Subcommittee members will receive pre-work to inform the subsequent meeting’s discussion

| **CCS Redesign Performance Measure Quality Subcommittee*** | |
|---|---|
| **Year** | **Meeting Date** |
| 2024 | Thursday, February 29 at 9-1 PT |
| 2024 | Thursday, May 30 at 11-1 PT |
| 2024 | Thursday, July 25 at 9-1 PT |
| 2024 | Wednesday, November 20 at 9-1 PT |

* Meeting days, times, and activities are subject to change

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# Workgroup Members

1. **Dr. Anand Chabra,** Medical Director, CCS and Family Health Services, San Mateo County Health
2. **Ann-Louise Kuhns,** President and CEO, California Children's Hospital Association
3. **Dr. Carlos Lerner,** President, California Children's Specialty Care Coalition and Vice Chair for Clinical Affairs, UCLA Dept of Pediatrics
4. **Carrie McKiddie,** Assistant Manager, Alpha Family Resource Center of Santa Barbara and Family Representative
5. **Dr. Chris Esguerra,** Chief Medical Officer, Health Plan of San Mateo
6. **Christine Betts,** Supervising Therapist, Monterey County CCS Therapy Program
7. **Cindy Spiva-Evans,** Family Representative
8. **Dr. Hannah Awai,** Medical Director, Sacramento County Public Health
9. **Jack Anderson,** Senior Fiscal & Policy Analyst, County Health Executives Association of California
10. **Dr. Jerry Cheng,** Chief, Department of Pediatrics, Los Angeles Medical Center; Regional PIC, Pediatric Specialties for Southern California Permanente Medical Group; Associate Professor, Kaiser Permanente School of Medicine
11. **Dr. Joanna Chin**, Medical Director, Contra Costa Health
12. **Katherine Barresi,** Senior Director Health Services, Partnership HealthPlan

# Workgroup Members

13. **Kelsey Riggs,** Manager, Pediatric Complex Case Management, Central California Alliance for Health
14. **Laurie Soman,** Director, Children's Regional Integrated Service System
15. **Dr. Louis Girling,** CCS Medical Director, Alameda County Public Health Department
16. **Dr. Mary Giammona,** Medical Director, Pediatrics and CCS Support Team, Molina Healthcare
17. **Dr. Michael Weiss,** VP of Population Health, Children's Hospital of Orange County
18. **Dr. Mona Patel,** Chief Integrated Delivery Systems Officer, Children's Hospital of Los Angeles
19. **Dr. Nwando Eze,** Regional Medical Director of Neonatology, Kaiser Permanente
20. **Dr. Ramiro Zúñiga,** Vice President, Medical Director, Health Net
21. **Sabina Keller,** CCS Public Health Nurse Supervisor, El Dorado County
22. **Shelby Stockdale,** Pediatric Health Services Manager, CenCal Health
23. **Tamica Foots-Rachal,** Project Director, Family Voices
24. **Dr. Thanh-Tam Nguyen,** Medical Director, Whole Child Model/Behavioral Health, CalOptima
25. **Dr. Thomas Shimotake,** President, California Association of Neonatologists (CAN); Medical Director, Intensive Care Nursery, Benioff Children's Hospital

# DHCS Staff

**Integrated Systems of Care Division (ISCD)**

- **Susan Philip,** Deputy Director, Health Care Delivery Systems
- **Joseph Billingsley,** Assistant Deputy Director, Integrated Systems
- **Cortney Maslyn,** Division Chief
- **Dr. Balaji Govindaswami,** Medical Director
- **Dr. Jill Abramson,** Associate Medical Director
- **Dr. Sabrina Atoyebi,** Branch Chief, Medical Operations
- **Barbara Sasaki,** Section Chief, Medical Operations
- **Erica Grant**, Unit Chief, Medical Operations
- **Olivia Thomas,** CCS Program and Policy Analyst

# DHCS Staff

**Enterprise Data and Information Management (EDIM) - Data Analytics Division (DAD) and Program Data Reporting Division (PDRD)**

- **Dr. Linette Scott,** Deputy Director and Chief Data Officer
- **Anne Carvalho,** DAD Division Chief
- **Dr. Eugene Stevenson,** PDRD Division Chief
- **Dr. Muree Larson-Bright,** DAD Research Scientist Manager
- **Michael Whitehead,** PDRD Research Data Supervisor II
- **Dr. Maricel Miguelino,** DAD Research Scientist Supervisor
- **Minerva Reyes,** PDRD Research Data Manager

# DHCS Staff

**Managed Care Quality and Monitoring Division (MCQMD)**

- **Dana Durham,** Division Chief, Managed Care Quality and Monitoring
- **Amara Bahramiaref,** Branch Chief, Managed Care Policy Branch
- **Ariana Hader-Smith,** Health Program Specialist II
- **Alyssa Hedrick,** Health Program Specialist I

**Quality and Population Health Management (QPHM)**

- **Dr. Palav Babaria,** Chief Quality and Medical Officer and Deputy Director of QPHM
- **Dr. Pamela Riley,** Chief Health Equity Officer and Assistant Deputy Director, QPHM
- **Dr. Sural Shah**, Chief, Quality and Health Equity Evaluation and Monitoring Branch
- **Dr. David Nessim,** Medical Consultant II, Quality and Health Equity Evaluation and Monitoring Branch
- **Annie Ima,** Health Program Specialist II, Quality and Health Equity Evaluation and Monitoring Branch

# Sellers Dorsey Staff

- **Meredith Wurden,** Senior Strategic Advisor/Subject Matter Expert
- **Alex Kanemaru,** Associate Director/Project Manager
- **Janel Myers,** Associate Director/Quality Subject Matter Expert
- **Olivia Brown,** Senior Consultant/Project Manager
- **Marisa Luera,** Director/Subject Matter Expert

# Subcommittee Discussion

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# Background

- In 2018, a CCS Performance Measures Quality Subcommittee was established and convened seven times to respond to the specific needs of the CCS population throughout the state
  - The goal of this Subcommittee was to create a standardized set of performance measures for a variety of distinct children's programs
  - This Subcommittee was composed of a multidisciplinary team of clinicians and program experts who were tasked with drafting, reviewing, and discussing the viability and technical specifications of performance measures
- Recommendations made by the 2018 CCS Performance Measures Quality Subcommittee will be considered as part of this process
- DHCS is convening the CCS Redesign Performance Measure Quality Subcommittee to identify and recommend measures for DHCS' consideration for implementation

# Authorizing Statute

Welfare & Institutions Code (WIC), section 14094.7 (b) requires DHCS to conduct the following activities by January 1, 2025:

- Annually provide an analysis on its website regarding trends on CCS enrollment for Whole Child Model (WCM) counties and non-WCM counties, in a way that enables a comparison of trends between the two categories of CCS counties.
- Develop utilization and quality measures, to be reported on an annual basis in a form and manner specified by the department, that relate specifically to CCS specialty care and report such measures for both WCM counties and non-WCM counties. When developing measures, the department shall consider:
  - Recommendations of the CCS Redesign Performance Measure Quality Subcommittee established by the department as part of the CCS Advisory Group pursuant to subdivision (c) of Section 14097.17.
  - Available data regarding the percentage of children with CCS eligible conditions who receive an annual special care center visit.

Source: WIC Section 14094.7 (b)

# Authorizing Statute (continued)

- Require, as part of its monitoring and oversight responsibilities, any Whole Child Model plan, as applicable, that is subject to one or more findings in its most recent annual medical audit pertaining to access or quality of care in the CCS program to implement quality improvement strategies that are specifically targeted to the CCS population, as determined by the department.
- Establish a stakeholder process pursuant to Section 14094.17.

*For WCM MCPs results from the measures identified in this process may inform quality improvement efforts.*

Source: WIC Section 14094.7 (b)

# Goals of the CCS Redesign Performance Measure Quality Subcommittee

- The goal of the CCS Redesign Performance Measure Quality Subcommittee is to advise on the identification and implementation of quality and outcome measures for the CCS and WCM dashboard to drive improvements in health outcomes for children and youth
- The Subcommittee will collaborate with external stakeholders including WCM Medi-Cal Managed Care Health Plans (MCP) and CCS Classic counties to create a dashboard that tracks program performance
- 3-5 total measures should be identified and compared among both programs so external stakeholders, MCPs, and the public may access this information through the dashboard
- When possible, there should be alignment between measures selected for WCM MCPs and Classic counties

# Goals of the CCS Redesign Performance Measure Quality Subcommittee (continued)

- The goal of the CCS Redesign Performance Measure Quality Subcommittee is to recommend a succinct list of measures for data collection and reporting
- The dashboard created by this effort will be utilized to improve CCS beneficiary health outcomes
- The list of measures recommended to DHCS will ultimately be leveraged to inform processes and potential needs for future initiatives from DHCS, county CCS programs, and MCPs
- The measures recommended to DHCS by this Subcommittee are separate and distinct from the CCS Compliance, Monitoring, and Oversight program

# May 30, 2024 Subcommittee Meeting Goals

- DHCS’ goals for today’s meeting are to:
  - Provide an update on the Demographic Dimensions Dashboard, which will be implemented on or by January 1, 2025
  - Review the subcommittee’s recommendations for Tier 1 measures and discuss DHCS’ Tier 1 measure selection

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# February Meeting Summary

During the quarterly February meeting, the Subcommittee reviewed and discussed the following topics:

- Domains and principles for measure selection
- Process for identifying candidate Tier 1 measures
- Process for and results of the Subcommittee’s vote on Tier 1 measures
- CCS case management definition

# DHCS Decision Points

Throughout the duration of this Subcommittee, we will log areas where there was consensus and DHCS confirmed decision points. This will be shared during each quarterly meeting in the table below.

| Meeting | DHCS Decision Points |
|---|---|
| August 2023 | Measures selected by the Subcommittee for DHCS' consideration will focus on the CCS population rather than the larger children and youth with special health care needs (CYSHCN) population |
| February 2024 | DHCS has opted for the inclusion of all proposed demographic dimensions in the initial iteration of the CCS dashboard, in addition to an independent/dependent county dimension |
| April 2024 | Based on the Subcommittee's recommendations, DHCS has finalized the slate of Tier 1 measures |

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# CCS Redesign Quality Roadmap

**January 1, 2025**

- Implementation begins January 1, 2025
- January 1 Dashboard will include existing *demographic data* based on Measurement Year (MY) 2024

**2026**

- Depending on data availability, MCPs and CCS programs submit MY 2025 data to DHCS
- When possible DHCS will pull the data

**2027**

- Data and reporting is published to dashboard on DHCS website for MY 2025

**2028+**

- Considerations for benchmarking begins

Existing *demographic data* outlined on a subsequent slide

# Demographic Dimension Inclusion Criteria

- DHCS is notifying the Subcommittee of the following reporting elements for inclusion in the dashboard:
  - CCS beneficiaries must be enrolled for a specific timeframe as set forth in the measure specifications
  - Data will be stratified by WCM and classic CCS programs, as DHCS deems applicable or set forth in measure specifications
  - At this time, the CCS only population will not be included in the dashboard. The rationale for exclusion includes:
    - Limited data and visibility of care delivered outside of the CCS program (WCM or classic CCS programs)

- More than 80% of CCS beneficiaries are enrolled in Medi-Cal (data as of July 2023)

# Demographic Data

- For January 1, 2025, implementation, the following demographic data will be included in the first iteration of the CCS dashboard (hereafter referred to as "demographic dimensions dashboard")*:

| Selected Demographic Dimensions | |
|---|---|
| Delivery System | County |
| Age | Healthy Places Index |
| Race | Population Density |
| Ethnicity | Plan |
| Sex | CCS |
| Primary Spoken Language | Year/Month |
| Foster Care/Child Welfare | Independent/Dependent County **(new)** |
| Eligibility Group | |

* Note: The CCS dashboard(s) created as a result of this Subcommittee effort are iterative. The name of the dashboard as well as included dimensions and subdimensions are at DHCS' discretion and are subject to change.

# Demographic Dimension Descriptions

| Dimension | Subdimensions | Notes |
|---|---|---|
| **Delivery System** | • Fee-for-service<br>• Managed care | • N/A |
| **Age** | • TBD | • DHCS is working to identify appropriate and clinically relevant age groups. |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **Ethnicity** | • Hispanic or Latino<br>• Not Hispanic or Latino<br>• Asked But No answer/Unknown | • DHCS is reviewing Race/Ethnicity reporting standards based on revised federal standards (OMB SPD 15 (2024)) |
| **Race** | • American Indian or Alaska Native<br>• Asian<br>• Black or African American<br>• Native Hawaiian or Other Pacific Islander<br>• White<br>• Some Other Race<br>• Two or More Races | • DHCS is reviewing Race/Ethnicity reporting standards based on revised federal standards (OMB SPD 15 (2024)) |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **Sex** | • Male<br>• Female | • Based on current data availability, DHCS must use sex rather than gender. |
| **Primary Spoken Language** | • Arabic<br>• English<br>• Farsi<br>• Korean<br>• Spanish<br>• Vietnamese<br>• Other | • The top reportable languages among the CCS population are included as subdimensions.<br>• Other languages may yield low sample sizes and cannot be displayed individually. |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **Foster Care/Child Welfare** | • Child Welfare (In-Home)<br>• Former Foster Youth (Ages 18-20)<br>• Foster Care<br>• Not Foster Care/In-Home | • N/A |
| **Eligibility Groups** | • MCHIP<br>• SCHIP<br>• Other | • DHCS is working to identify which eligibility groups are most relevant to the CCS population and will update this list as needed. |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **County** | • All California counties | • N/A |
| **Healthy Places Index (HPI)** | • Quartile 1 (Less Healthy Community Conditions)<br>• Quartile 2<br>• Quartile 3<br>• Quartile 4 (Healthier Community Conditions) | • HPI was created by the Public Health Alliance of Southern California to advance health equity through open data. The HPI maps data on various social indicators.<br>• DHCS will track this dimension based on census tract. |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **Population Density** | • Frontier (population density of less than 11 persons per square mile)<br>• Rural (population density of less than 250 persons per square mile; no population center exceeds 50,000 individuals)<br>• Urban (population range 75,000-125,000 individuals; five or more square miles)<br>• Other | • Population density is based on Medical Service Study Areas (MSSAs) and describes the number of people per square mile within one or more census tracts. |
| **Plan** | • All WCM Medi-Cal Managed Care Plans (MCPs) will be listed out separately<br>• Fee-for-service/other | • N/A |

# Demographic Dimension Descriptions (continued)

| Dimension | Subdimensions | Notes |
|---|---|---|
| **CCS** | • CCS – Classic<br>• CCS – Whole Child Model (WCM)<br>• Non-CCS | • N/A |
| **Year/Month** | • Year<br>• Month | • N/A |
| **Independent/ Dependent Counties** | • Independent counties (population > 200,000 individuals)<br>• Dependent counties (population <200,000 individuals; CCS program jointly administered with DHCS) | • This is a newly added dimension.<br>• DHCS has opted to add this dimension to align with CCS program structure. |

# Demographic Dimensions Dashboard

- DHCS has convened a cross-departmental team to develop, build, and implement a demographic dimensions dashboard on 1/1/2025
- It is currently in the proof-of-concept phase and will evolve as DHCS continues internal conversations
- The demographic dimensions dashboard will be interactive and based on the Telehealth Dashboard DHCS published in April 2024

# Demographic Dimensions Dashboard (continued)

- The dashboard will allow users to filter the data according to CCS or WCM counties
- DHCS is working to identify dimensions that can be stacked
  - Due to small counts and additional considerations, the ability to stack dimensions will be limited

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# Tier 1 Approach for Measure Recommendations

- **Tier 1: Assess core CCS program functions such as CCS specialty care and are presently feasible for implementation.** During the February 29th meeting, Subcommittee members:
  - Reviewed and discussed proposed Tier 1 measures
  - Voted on candidate measures for Subcommittee recommendation to DHCS

The Subcommittee's main charge is to advise DHCS on Tier 1 measures for January 1, 2025, implementation.

**Tier 1 measures should include those outlined in AB 118 (WIC, Section 14094.7b), specifically those related to CCS program functions including CCS specialty care** that are feasible for implementation.

# Voting Process

- During the February 29th Subcommittee meeting, Subcommittee members had the opportunity to vote on each of the candidate measures
  - During discussion, Subcommittee members suggested the "Total requests for DME authorizations and approval rate" measure be moved to Tier 2 and therefore was not included in Tier 1 vote
- If a measure received a "yes" vote from 60% or more of the Subcommittee, it was considered as a recommendation to DHCS for Tier 1 measures
- If a measure received a 40-59% "yes" vote, there was additional Subcommittee discussion and a second round of voting
- If a measure received <39% "yes" vote, it was not proposed as a recommendation to DHCS
- DHCS reserves the right to move forward with any Tier 1 measures it believes are relevant and valuable to track

# Summary of Tier 1 Vote

| Measure Name | Result of First Vote | Result of Second Vote, if needed |
|---|---|---|
| **CCS Paneled Provider Utilization** | 100% | |
| **Ambulatory Care – Emergency Department (ED) Visits** | 74% | |
| **Inpatient (IP) Admissions** | 100% | |
| **Pediatric All-Condition Readmission** | 100% | |
| **CCS beneficiaries with select conditions who have a documented visit with a SCC within 90-days of referral** | 100% | |
| **Transcranial Doppler Ultrasonography (TCD) Screening among Children with Sickle Cell Anemia** | 39% | |
| **CCS Beneficiaries with Hearing Related Condition** | 61% | |
| **Childhood Immunization Status (CIS)** | 42% | 39% |
| **Immunizations for Adolescents Combination 2 (IMA-2)** | 42% | 39% |
| **Child and Adolescent Well-Care Visits (WCV-CH)** | 37% | |
| **Well Child Visits in the First 30 Months of Life (W30-CH)** | 37% | |

# Selected Tier 1 Measures

- DHCS is moving forward with these six Tier 1 measures, which received over 60% of the Subcommittee's vote:
  - CCS Paneled Provider Utilization
  - Ambulatory Care – Emergency Department (ED) Visits
  - Inpatient (IP) Admissions
  - Pediatric All-Condition Readmission
  - CCS beneficiaries with select conditions who have a documented visit with a SCC within 90-days of referral*
  - CCS Beneficiaries with Hearing Related Condition

*This measure must be included in Tier 1 in alignment with the authorizing statute, which requires DHCS to collect data regarding the percentage of children with CCS eligible conditions who receive an annual special care center visit.

# Selected Tier 1 Measures (continued)

- Based on relevance to the CCS population, feasibility of the measures, and data availability, DHCS determined that it is critical to track the two preventive measures below.
  - Childhood Immunization Status (CIS)
  - Immunizations for Adolescents Combination 2 (IMA-2)
    - Note: This measure will also be included in the forthcoming 2024 refresh of the CCS Quality Dashboard, which is separate from the Tier 1 Measure dashboard efforts.
- DHCS will include these measures in Tier 1 in alignment with DHCS's renewed focus on population health, preventative care, and wellness as the foundation of all health care and care navigation.

# Tier 1 Measure Stratification

- During the February Subcommittee meeting, Subcommittee members asked that DHCS consider stratifying select Tier 1 measures, as appropriate
- As such, DHCS is in the process of evaluating a condition-based stratification approach based on feasibility and data availability
- DHCS reserves the right to limit or eliminate stratification for Tier 1 measures in alignment with data and resource availability

# Rationale for Stratification Approach

- For a CCS-eligible condition to be considered for Tier 1 stratification, it must meet each of the following criteria:
  - Sizeable prevalence relative to other rare diseases (i.e., several hundred new cases annually)
  - Definitional clarity and condition homogeneity
  - Conditions are chronic, complex, and, if left untreated, would result in loss of life or significant disability
  - Children with the condition(s) are typically seen by specialists in specialty clinics multiple times per year
  - Conditions require extensive case management
  - Exciting new cellular/gene therapies (CGT) and medical/surgical technologies exist for these conditions

# Selected CCS-Eligible Conditions for Stratification

- Based upon the criteria listed on the previous slide, DHCS is considering the following CCS-eligible conditions for stratification of Tier 1 measures, as appropriate:
    1. Type 1 Diabetes Mellitus
    2. Hemophilia
    3. Sickle Cell Anemia
    4. Acute Lymphocytic Leukemia
    5. Cystic Fibrosis

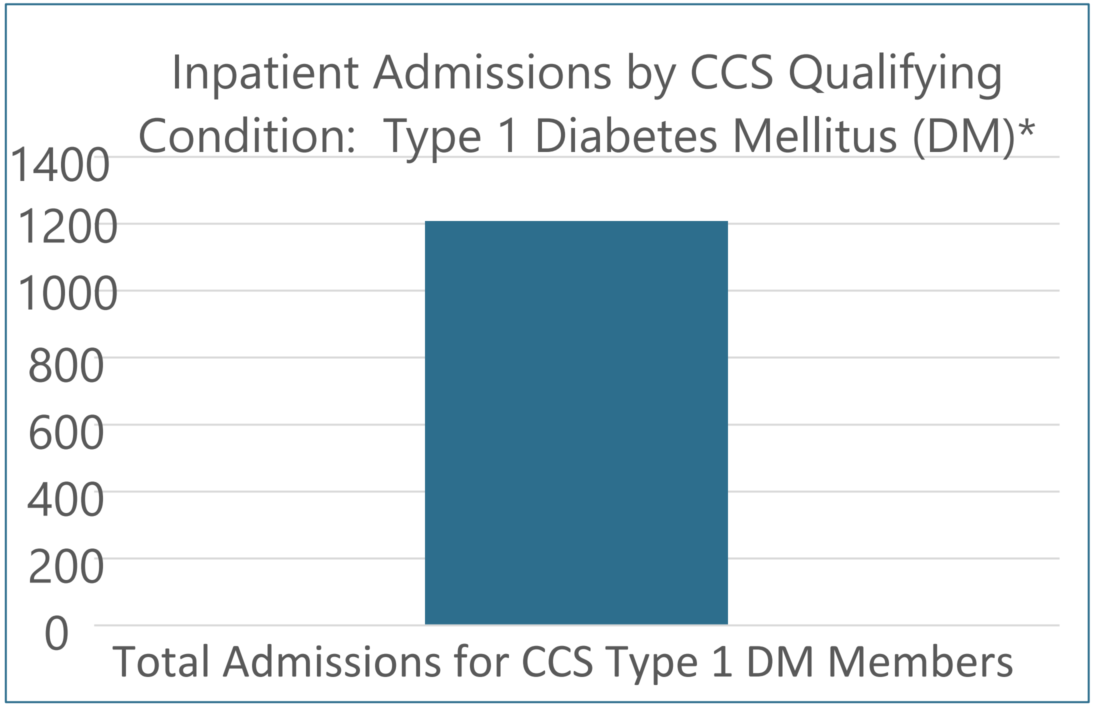
# Limitations of Tier 1 Stratification

- DHCS understands the Subcommittee is interested in stratifying Tier 1 measures to identify whether the measure outcome is related to the CCS-eligible condition
- Given current resource limitations, DHCS is unable to develop a stratification of that complexity
- Additionally, due to small counts many of the quality measure condition-stratified rates would have to be suppressed
- However, DHCS believes it is feasible to stratify Tier 1 measures by the CCS member’s qualifying condition

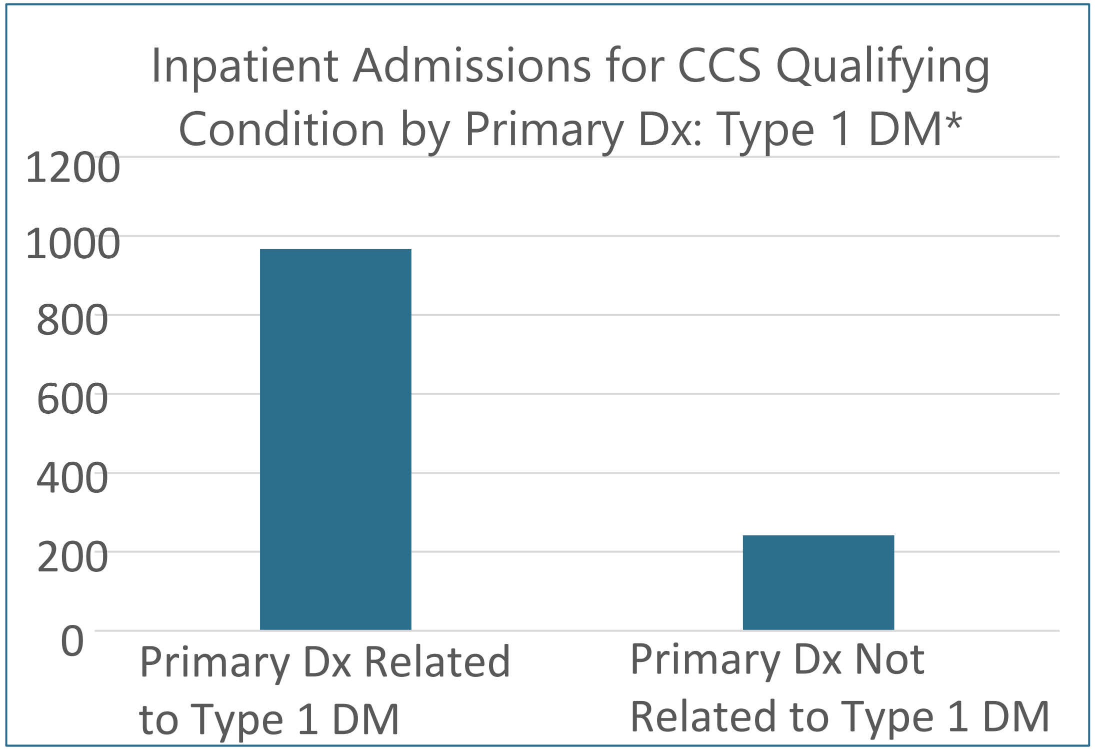
# Limitations of Tier 1 Stratification, continued

- Example of feasible versus unfeasible condition stratification for Inpatient Admissions Tier 1 measure

**Feasible: Stratification of CCS Eligible Condition by Measure**



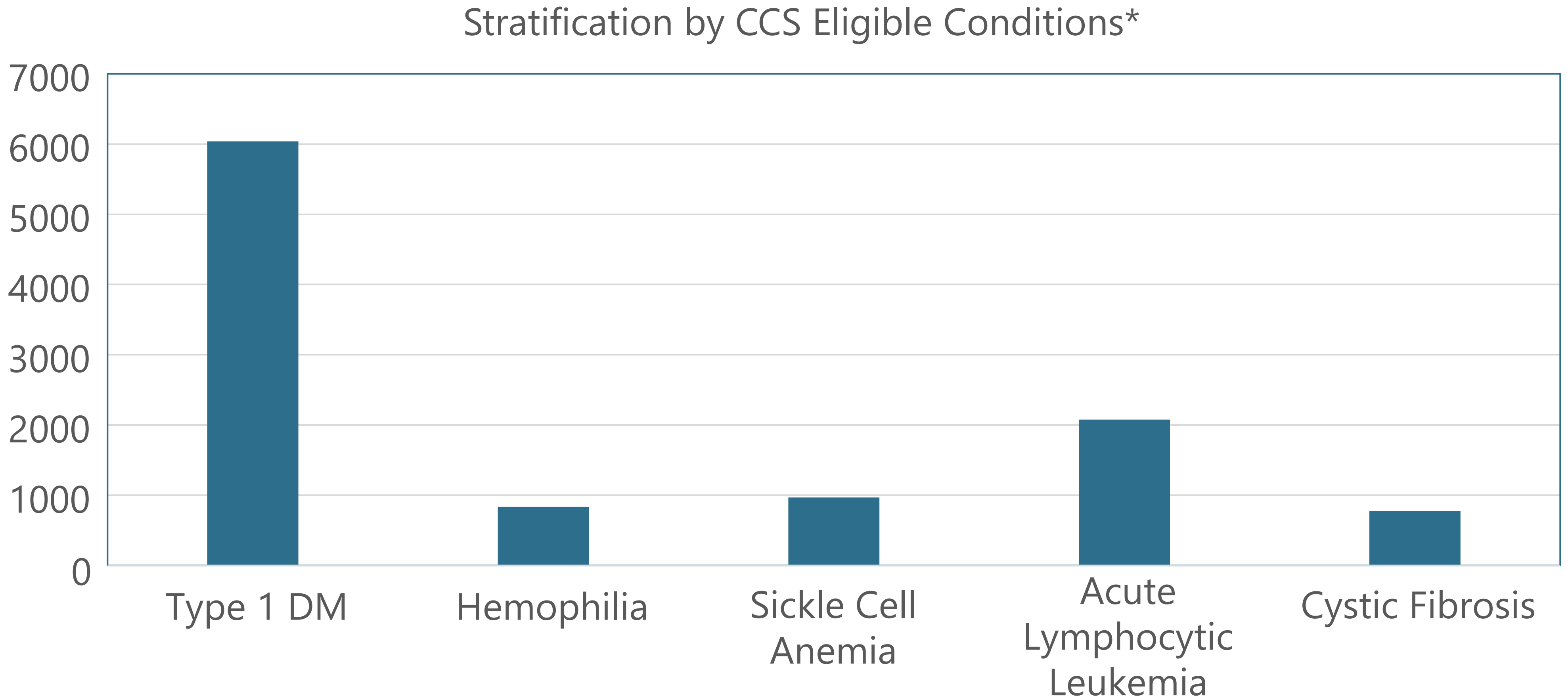
**Unfeasible: Stratification by CCS Eligible Condition and Primary Diagnosis (Dx)**



*These graphs and associated counts were created using mock data and do not reflect current CCS counts.

# Limitations of Tier 1 Stratification, continued

- Example of stratification by selected CCS-eligible condition:



*Counts are using mock data and do not reflect updated CCS counts.

# Selected Condition: Type 1 Diabetes Mellitus

- Overview
  - Form of insulin-dependent diabetes resulting in chronic endocrine insufficiency
  - No known method of prevention
  - Typically presents between 4 and 7 years old or 10 to 14 years old
  - American Heart Association categorizes children with Type 1 DM in the highest tier for cardiovascular risk
- Prevalence
  - 2/10,000 prevalence for individuals ages 0-19 years nationally from 2003-2015
  - Estimated CCS population is slightly over 6,000 beneficiaries

# Selected Condition: Hemophilia

- Overview
  - Inherited bleeding disorder
  - Almost exclusively affects males (i.e., x-linked)
  - Potential transfusion-dependence and various complications
  - Likely to develop chronic age-related comorbidities (e.g., heart disease) and treatments can create challenges that may increase risk of bleeding
- Prevalence
  - Estimated prevalence of 30,000-33,000 males nationally
  - Estimated CCS population is slightly under 850 beneficiaries

# Selected Condition: Sickle Cell Disease

- Overview
  - Genetic condition present at birth
  - Complications include pain crises, anemia, transfusion-dependence, iron overload, infections, vision loss, and stroke
- Prevalence
  - Affects approximately 100,000 Americans, with higher prevalence among Black/African American populations
  - Estimated CCS population is slightly over 900 beneficiaries

# Selected Condition: Acute Lymphocytic Leukemia (ALL)

- Overview
  - ALL develops when lymphocytes develop DNA mutations, crowding out healthy cells
  - Genetic (e.g., Down syndrome) and environmental risk factors
- Prevalence
  - 60% of ALL cases occur in children, but 80% of ALL deaths occur in adults
  - Highest ALL risk for children under 5 years of age
  - Estimated CCS population is slightly over 2,000 beneficiaries

# Selected Condition: Cystic Fibrosis

- Overview
  - Genetic disease caused by variation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene, affecting cells that produce mucus, sweat and digestive juices
  - Digestive, respiratory, nutritional, infectious, liver, bone and reproductive system complications
  - Chronic condition that worsens over time
- Prevalence
  - Prevalence of approximately 40,000 individuals nationally in 2020
  - CCS population within California is estimated at slightly over 750 enrollees

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| Review of Recommended Tier 1 Measures and DHCS Decisions | 12:00-12:45 |
| Public Comment | 12:45-12:55 |
| Next Steps | 12:55-1:00 |

# Next Steps

- DHCS will share a Meeting Summary following today’s meeting
- Ahead of the July Subcommittee Meeting, DHCS may send Workgroup members pre-work, as needed

# Contact Information

- For more information, questions, or feedback regarding the CCS Redesign Performance Measure Quality Subcommittee, please email Olivia Brown Olivia.Brown@dhcs.ca.gov
- For assistance in joining the CCS Redesign Performance Measure Quality Subcommittee meetings, including information about meeting details and obtaining assistive services, please email CCSProgram@dhcs.ca.gov with the Subject Line: “CCS Redesign Performance Measure Quality Subcommittee”

# Thank you

# Appendices

# Domains

- Domains are conceptual groupings or categories of measures. Measures are used to assess a structure, process, or outcome pertaining to a program
- Measures may overlap domains
- Measures that fall under each domain will be provided for the Subcommittee's consideration
  - New and validated measures brought forth by Subcommittee members will also be considered throughout this process when raised by a Subcommittee member

# Domains

- The following domains have been identified for the Subcommittee's consideration and based on the 2018 CCS Performance Measure Quality Subcommittee; however, domains are not limited to the following list:

1. **Access to Care** refers to the ability of having timely use of personal health services to achieve the best health outcomes
2. **Care Coordination** refers to a "function that helps ensure that the beneficiaries' needs and preferences for health services and information sharing across people, functions, and sites are met over time"*
3. **Family Participation/Satisfaction** encompasses the range of interactions that beneficiaries have with the health care system, including their CCS and WCM county programs, Medi-Cal MCP, and from doctors, nurses, and staff in hospitals, physician practices, and other health care facilities
4. **Clinical Quality of Care** refers to the degree to which health care services for individuals and populations increase the likelihood of a desired health outcome and are consistent with current professional knowledge
5. **Utilization** refers to ensuring beneficiaries receive the proper care and requires services without over or under using resources
6. **Transition to Adulthood** refers to the process of preparing adolescents and families to move from a pediatric to an adult model of care

* Care Coordination Endorsement Maintenance, NQF

# Principles for Measure Recommendations

- The Principles for Measure Recommendations developed for this Subcommittee:
  - Allow Subcommittee members to have necessary guardrails needed to prioritize and recommend measures that reflect the values and goals for this effort
  - Necessary to recommend a succinct set of 3-5 measures that can be implemented in a timely manner and will enable quality of care improvement for CCS Classic and WCM beneficiaries
  - Drawn from similar efforts conducted at the state and national levels and are in accordance with the goals of this specific initiative
  - Not meant to be absolute, but to provide guidance in thinking about each measure and the balance of the entire set as a whole
  - Have been shared amongst Subcommittee members for input and feedback

# Principles for Measure Recommendations (continued)

**The Principles for Measure Recommendations include:**

1. **Meaningful** to the beneficiaries, their families, the state, CCS Classic, and WCM programs, and the public
2. **Improves quality and equity of care** or services for CCS Classic and WCM beneficiaries
3. **High population impact** by affecting large numbers of CCS beneficiaries or having substantial impact on smaller, special populations
4. **Known impact of poor quality** linked with severe health outcomes (morbidity, mortality) or other consequences (high resource use)
5. **Performance improvement needed** based on available data demonstrating opportunities for achievable improvement in program performance that could improve quality of care or reduce inequities in care for CCS beneficiaries

# Principles for Measure Recommendations

- The Principles for Measure Recommendations have been identified for the Subcommittee's consideration; however, principles are not limited to this list
- Each principle should be applied to measures reviewed and discussed as part of this Subcommittee
- There may be instances when discussing measures specific to the CCS program functions that do not apply to all Principles for Measure Recommendations

# Principles for Measure Recommendations (continued)

6. **Evidence based practices available** to demonstrate that the problem is amenable to intervention and there are pathways to improvement
7. **Availability of standardized measures (including measure specifications) and data** that can be collected
8. **Alignment** with other national and state priority areas
9. **Feasibility** data source are available to appropriately calculate the measures and there is capacity at the state, MCP, and/or CCS program levels to collect the required data

# Types of Data

- **Administrative data:** Gathered from claims, encounter, enrollment, and providers systems
- **Medical records:** Patient’s medical history and care
- **Hybrid:** Administrative data supplemented with medical record review
- **Electronic clinical data:** Patient-level information pushed in an interoperable electronic format
- **Surveys:** Capture self-reported information from patients on health care experiences

# Data and Reporting Capabilities: MCPs

- To promote better health outcomes and preventive services, DHCS requires MCPs to report annually on a set of quality measures, known as the Medi-Cal Managed Care Accountability Set (MCAS) performance measures
- MCPs also participate in pay-for-reporting or pay-for-performance programs, for which data reporting is a requirement of participation or incentive payment
- **Data**
  - Demographic data through DHCS
  - Encounter data based on claims submitted by a provider to the MCP
  - Hybrid data consisting of encounter data and chart reviews. (This process is very time consuming and nationally the use of this data is trending downward)
  - Plan reported data for incentive programs or new benefits
- **Limitations**
  - Encounter data lag or the period between the date of service and the date the claim is submitted to the MCP. Medi-Cal data is considered complete after 12 months following the date of service.
  - Continuous enrollment in a MCP is required for an individual to be included in many nationally recognized measures

# Data and Reporting Capabilities: County CCS Programs

- Children's Medical Services (CMS) Net is a full-scope case management system for the CCS program
- CMS Net is a web-based tool that enables approved counties, CCS providers and WCM MCPs to electronically access the status of Service Authorization Requests (SARs)
- **Data Types**
  - Demographic data through DHCS
  - Prior authorization data via SARs
  - Insurance coverage
  - Participant count, client eligibility summary, ICD-diagnosis, Medi-Cal eligibility, registration, case notes, other
- **Limitation**
  - Challenges include non-standardized data collection in CMS Net, variance in wording and interpretation of measures, and workload to report on measures
  - Available data sets vary by entity and frequency of data pulls vary by report types
  - Differences may exist in the data quality between county CCS programs and MCPs

# Key Terms: Quality Measures

- **Effectuate:** To put the measures into operation
- **Quality measure**: Tools that help us measure or quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care
  - Goals include: effective, safe, efficient, patient-centered, equitable, and timely care*
- **Elements of a quality measure**:
  - Title and description of what the measure is
  - Numerator: the subset of the denominator population for which a clinical action or outcome of care occurs
  - Denominator: includes the population eligible for the services or outcomes assessed in the measure
    - Some measures include exceptions/exclusions
- "Quality measure" and "performance measure" are often used interchangeably

* Quality Measures Definition, Centers for Medicare and Medicaid (2023)

# Key Terms: Types of Quality Measures

The following outlines the different types of quality measures that are commonly used:

1. **Structural:** Characteristics of the organization, such as facilities, staff, and equipment.
2. **Process:** Focuses on steps that should be followed to provide quality care. There should be evidence-based best practices for when the process is executed well, will increase the probability of achieving a desired outcome.*^
3. **Outcome:** Evaluate impact of service or intervention. Often multifactorial and can take time to improve.
4. **Patient Experience:** Reflect the beneficiary's perspective related to their experience (interactions with health system) and satisfaction (evaluation of the care provided, relative to their expectations)

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* Types of Measures, Centers for Medicare and Medicaid (2023)

^ What are the Types of Quality Measures?, NCQA (2016)

# 2018 CCS Domains and Performance Measures

| Access to Care |
|---|
| Percentage of children and youth with special health care needs (CYSHCN) 1 – 19 years of age who had a visit with a primary care provider/practitioner (PCP) during the calendar year* |
| Percentage of CCS-enrolled children 12 years of age and older who were screened within a calendar year for clinical depression using a standardized tool and, if screened positive, who received follow-up care<br>Percentage of CCS-enrolled children 12 years of age and older who screened positive for depression within the calendar year and received follow-up care within 30 days |
| Utilization of out-patient (OP) visits for CYSHCN<br>Utilization of prescriptions for CYSHCN<br>Utilization of mental health services for CYSHCN |

* Similarly, for CCS Monitoring and Oversight Program efforts the measure "Percentage of CCS beneficiaries who had an annual authorized Specialty Care Center (SCC)/Specialist visit" has been proposed as part of the Quarterly Reporting process.

# 2018 CCS Domains and Performance Measures

| Care Coordination |
|---|
| Percentage of CYSHCN with select conditions (cystic fibrosis, hemophilia, sickle cell, leukemia, diabetes) who have a documented visit with a SCC within 90-days of referral |
| The number of acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30-days; and had a predicted probability of an acute readmission for CCS enrolled children <21 years of age |
| Utilization of emergency room (ER) visits for CYSHCN<br>Utilization of ER visits with an IP admission for CYSHCN<br>Utilization of IP admissions for CYSHCN |
| Percentage of CYSHCN discharged from a hospital who had at least 1 follow-up contact with a PCP or Specialist or visit (face-to-face or telemedicine) within 28 days post-discharge |

# 2018 CCS Domains and Performance Measures

| **Family Participation (Family-Centered Care)** |
|---|
| • Family satisfaction by annual survey<br>• Family participation by annual survey |
| **Quality of Care** |
| Percentage of CYSHCN at 2 years of age who had appropriate childhood immunizations |
| Percentage of CYSHCN with type 1 or type 2 diabetes mellitus who had a most recent hemoglobin A1c (HbA1c) <8% |
| **Transition Services** |
| CYSHCN 14+ years of age who are expected to have chronic health conditions that will extend past their 21st birthday will have biannual review for long-term transition planning to adulthood |